RECEIVED 5/10/07

PRINTED: 05/04/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G155	A. BUILDING _____ B. WING _____	04/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	2268 SUDBURY ROAD, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from April 17, 2007 through April 19, 2006. The survey was initiated using the fundamental survey process. A sample of three clients was selected from a resident population of six men with various disabilities. One of the six men that resided in the facility was in the hospital at the time of the survey. He was added for a focused review. The findings of the survey were based on home and two day program observations, interviews with clients (2), legal guardians, staff and consultants and well as a review of medical, habilitation and administration records, including incident reports.	W 000		
W 112	483.410(c)(2) CLIENT RECORDS The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to keep confidential all information contained in each client's record, for six of the sixc clients residing in the facility. (Clients #1, #2, #3 ,#4, #5 and #6) The findings include: 1. On April 17, 2006, at approximately 8:10 AM, Clients #1, #2, #3, #4, #5, and #6's habilitation records, which include personal and sensitive information were stored on shelves located in a common area (vestibule) of the facility. Interview with the Qualified Mental Retardation	W 112	W 112 The Agency has implemented a system to ensure that all client records and pertaining information is secured and kept confidential. In the future the Agency will ensure that client records are kept secured in a locked cabinet and made accessible to authorized personnel only. Client's diet orders will be placed in the front of the Menu Books.	5/8/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan J. Sloan BSQ MA TITLE: VP (X6) DATE: 5/9/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 05/04/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G155	A. BUILDING _____ B. WING _____	04/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	2269 SUDBURY ROAD, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 112	Continued From page 1 Professional (QMRP) at 5:30 PM revealed that this was the standard method and location for storing the client records. The facility failed to store confidential records in an area where visitors and unauthorized personnel could not have easy access. 2. On April 17, 2006, at 5:05 PM, the client's diets were observed posted on the facility's bulletin board. On April 18, 2007 at 2:50 PM, Client #2's weights were observed posted on a bulletin board in the facility's basement. The facility failed to implement a system that ensures confidentiality of the clients' personal information.	W 112		
W 114	483.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly, date it, and sign it. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each client's records were dated for one of six clients residing in the facility. (Client #6) The finding includes: Interview with Qualified Mental Retardation Professional (QMRP) and review of the agency's Unusual Incident Log was conducted on April 17, 2007 at 9:01 AM. An incident report dated August 25, 2006 revealed that Client #6 picked his left fore arm below his elbow. Another incident dated September 19, 2006 revealed that facility's door slammed in Client #6's face.	W 114	W 114 The Agency has revised the Incident Management Policy and Procedure to ensure that there are - weekly incident reviews - monthly incident reviews at HRC meetings - quarterly incident trending reports The Incident report has been revised to include date and time of notification of administrator. Attached - Incident report - Incident Management Policy & Procedure	5/8/07

PRINTED: 05/04/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G155	A. BUILDING _____ B. WING _____	04/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	2268 SUDBURY ROAD, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 114	Continued From page 2 Further review of the log revealed investigative summaries for the aforementioned incidents. The investigative summary regarding the August 25, 2006 incident failed to evidence the dates of the completed investigation. Additionally, review of the investigative summary for the September 2006 incident failed to evidence a signature and a date. It should be noted that the investigative summary had a designated line at the bottom of the form requiring a signature and date.	W 114		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure outside services met the needs of one of the three clients included in the sample. (Client #1) The finding includes: 1. On April 17, 2007, beginning at approximately 10:57 AM, Client #1 was observed at his day program. The client was weaving strands of string on a pot holder loom. He remained focused on the task, while his assigned 1:1 staff person stood in an adjacent hallway. When asked about the client's skills, a day program staff indicated that the client was able to read and he could write his last name. The day program activities coordinator indicated the client's programs focused on recreation and	W 120	W 120 -1 A Vocational Assessment will be scheduled. The client's IPP has been revised to reflect the client's pre-vocational objectives. Attached - Revised Day Program IPP	5/30/07

PRINTED: 05/04/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G155	A. BUILDING _____ B. WING _____	04/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	2288 SUDBURY ROAD, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 120	Continued From page 3 leisure activities such as making jewelry and painting. The ISP recommended that the day program develop an objective to perform 6 prevocational tasks within 12 months. Review of both the day program and residential IPP failed to reflect prevocation objectives. Additionally, there was no evidence that the client had been assessed to determine vocational needs. The Qualified Mental Retardation Professional (QMRP) was interviewed later that day in the facility. At approximately 2:40 PM, she stated that Client #1 had not received a comprehensive vocational assessment. 2. Cross Reference [W159] The QMRP failed to provide Client #2's day program with adaptive feeding equipment. Observations at the day program on the same day at 12:24 PM, revealed Client #2 eating his lunch using a regular plate. On April 17, 2007 at 7:07 PM, Client #2 was observed eating his dinner using a scoop plate. Review of the habilitation record on April 18, 2007 at approximately 9:00 AM revealed that the client had an Occupational Therapy Assessment dated October 30, 2006. A recommendation was made to "discontinue the use of a plate guard at meatime and replace with a scoop dish." Interview with the QMRP on April 18, 2007 revealed that the client was to have a scoop plate at the day program. At the time of the survey, there was no evidence that the facility provided the day program with the necessary adaptive	W 120	W 120 - 2 The Day Program has been provided with the high sided plate. In the future the Agency has implemented a system to ensure continuity of care at the day programs. All QMRPs and nurses will visit the Day Programs on a monthly basis and document the findings. Attached - Monthly Day Program visit Record	5/9/07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/04/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G155	A. BUILDING _____ B. WING _____	04/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	2268 SUDBURY ROAD, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 120	Continued From page 4 equipment.	W 120		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the rights of each client and/or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment, for one of the three clients in the sample. (Client #2) The finding includes: Observation of the evening medication administration on April 17, 2007, revealed that Client #2 received Risperdal 2mg. Interview with the medication nurse during the administration of the medication revealed the medication was used to manage behaviors. Interview with the Qualified Mental Retardation Professional (QMRP) on April 17, 2007 at 2:10 PM revealed that Client #2 received psychotropic medications and had a Behavior Support Plan (BSP). Review of Client #2's BSP dated July 6, 2006 revealed the plan addressed a targeted behavior of physical aggression. Further	W 124		

PRINTED: 05/04/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G155	A. BUILDING _____ B. WING _____	04/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	2268 SUDBURY ROAD, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 124	Continued From page 5 interview with the QMRP on April 18, 2007 revealed Client #2's mother was his legal guardian. This information was verified by the review of Client #2's habilitation record. Further review of the record revealed that Client #2 had a Psychological Assessment dated July 6, 2006. According to the assessment, Client #2 " is not competent to make independent decisions concerning his residential and day placements, program plan, medical treatment, or financial affairs. He lacks the cognitive judgment and academic skills to understand the implications of these decisions, and therefore cannot give his informed consent." Client #2's mother visited the facility on April 18, 2007 at 12:00 PM. At 4:22 PM,the QMRP submitted an informed consent for Client #2's psychotropic medication. The consent had been signed by his legal guardian on the day of the survey (April 18, 2007). At the time of the survey, the facility failed to provide evidence that Client #2's treatment needs, including the benefits and potential side effects associated with the medications, and the right to refuse treatment, had been explained to him and/or his legal guardian prior to starting the medications.	W 124	W 124 The Agency has developed a database for clients who receive psychotropic medication, restrictive and adaptive equipment and who have BSPs, so that a tickler system can ensure that all consents are reviewed, signed and completed in a timely manner. Attached - client database tickler system	5/8/07
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by:	W 149		

PRINTED: 05/04/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G155	A. BUILDING _____ B. WING _____	04/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	2288 SUDBURY ROAD, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 6 Based on interview and record review, the facility failed to establish and/or implement policies that ensure the health and safety of six of the six clients that reside in the facility. (Clients #1, #2, #3, #4, #5, and #6) The findings include: The facility failed to ensure its incident management policy coincided with federal requirements. An interview was conducted with the facility's Qualified Mental Retardation Professional (QMRP) on April 17, 2007 at 2:27 PM to ascertain if the facility had a written incident management policy. The QMRP indicated that they had an incident policy and verified it by providing a copy for surveyor's review. Review of that policy on April 17, 2007 failed to address injuries of unknown origin and reporting such injuries to the Administrator. (See W153)	W 149	W 149 The Agency has revised the Incident Management Policy and Procedure to ensure that there are - weekly incident reviews - monthly incident reviews at HRC meetings - quarterly incident trending reports - incidents of unknown origin The Incident report has been revised to include date and time of notification of administrator.	5/9/07
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all allegations of abuse and/or neglect as well as injurious of unknown source were immediately reported to the	W 153	W 153 Refer to W149	5/8/07

PRINTED: 05/04/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G155	A. BUILDING _____ B. WING _____	04/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	2268 SUDBURY ROAD, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 153	Continued From page 7 administrator or to the Department of Health in accordance with State law, for one of the three clients in the sample. (Client#1 The findings include: Review of the facility's incident reports on April 17, 2007 at 9:01 AM revealed an injury of unknown source involving Client #1 as evidenced below. On September 24, 2006, staff reported that Client #1 was discovered with a bruise on the right side of his face. Review of the investigative summary (not dated) revealed a counselor noticed a mark under the client's right eye. On the next day (September 25, 2006) the client 's eye "appeared reddened and he was transported to the emergency room on Septerber 27, 2006. At the time of the survey, the facility failed to provide evidence that the aforementioned incident was reported to the facility's administrator or other official in accordance with state law.	W 153		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility ' s Qualified Mental Retardation Professional (QMRP) failed to adequately monitor, integrate and coordinate each client 's active treatment.	W 159		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/04/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G155	A. BUILDING _____ B. WING _____	04/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	2268 SUDBURY ROAD, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	(Continued from page 8)	W 159		

The findings include:

1. The QMRP failed to ensure that the day program had been informed of Client #1's diet order changes as evidenced below:

On April 17, 2007 at 12:17 PM, Client #1 was observed eating his lunch. The client was served Spaghetti with meatballs and carrots. Further observation of the meal revealed that all of the client's food was chopped.

On April 17, 2007 at 5:05 PM all of the clients diet orders were posted on the bulletin board in the kitchen. Client #1's diet order reflected a regular diet with chopped vegetables. Interview with the nurse and review of physician orders verified the posted order.

Interview with the facility's nurse on April 18, 2007 to ascertain information regarding how information regarding changes in the client's diet order is communicated to the day program. The nurse indicated that whenever there is a change in an order, the facility faxes it first to the pharmacy, and then to the Primary Care Physician (PCP). She also indicated that information is usually hand delivered by the direct care staff when transporting the clients to the day program.

An Interview was conducted with the day program staff on April 17, 2007 to ascertain if there had been any changes made to Client #1's diet. According to the day program staff they had not been made aware of any changes.

At the time of the survey, there was no documented evidence that the day program had

W 159-1
In the future the Agency has implemented a system to ensure continuity of care at the day programs.
-All QMRPs and nurses will visit the Day Programs on a monthly basis and document the findings.
-Physicians Order Sheet with the corrected diet order has been given to the Day Program and henceforth all Physicians' order changes will be communicated with the day program within 1 working day
-Day Program Staff have been in serviced regarding the change in the diet order.

5/9/07

PRINTED: 05/04/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G155	A. BUILDING _____ B. WING _____	04/18/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	2266 SUDBURY ROAD, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 180	Continued From page 9	W 152		
	been informed of the change in Client #1's diet order 2. The QMRP failed to ensure Client #2 was provided with adaptive feeding equipment at his day treatment program as recommended. Observations at the day program on April 17, 2007 at 12:24 PM, revealed Client #2 eating his lunch using a regular plate. Observations at the home, however, the client was eating from a scoop plate. Review of the habilitation record on April 18, 2007 at approximately 9:00 AM revealed that the client had an Occupational Therapy Assessment dated October 30, 2006. A recommendation was made to "discontinue the use of a plate guard at mealtime and replace with a scoop dish." Interview with the QMRP on April 18, 2007 revealed that the client was to have a scoop plate at the day program and would ensure that one would be provided for him. At the time of the survey, there was no evidence that the facility provided the day program with the necessary feeding adaptive equipment for Client #2. 3. Cross-refer to W322. The QMRP failed to ensure that the nutritionists' recommendation for client #1 had been addressed.		W 159 -2 The Day Program has been provided with the high sided plate. In the future the Agency will ensure that all client's orders and changes are reflected on the Physician's Order sheet and that the Day Program is provided with a copy of the new POS within 1 working day. The Agency has started an Audit program which is done monthly by a QMRP and House Manager. Attached – Audit sheets W 159-3 Refer to W322 and see attached	5/9/07
W 209	483.440(c)(2) INDIVIDUAL PROGRAM PLAN Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate.	W 209		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/04/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G155	A. BUILDING _____ B. WING _____	04/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	2268 SUDBURY ROAD, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 209	Continued From page 10 This STANDARD is not met as evidenced by: Based on record review and interview, it could not be determined if two of the three clients in the sample participated in their annual meetings. (Clients #1and #2) The findings include: 1. Interview with the Qualified Mental Retardation Professional (QMRP) on April 18, 2007 revealed all the client's in the facility including Client #1 participated in their Individual Support Plan (ISP) meetings and are encouraged to participate as much as possible. Review of the attendance record dated July 16, 2006 annual meeting did not include Client #1's name. Further review of the ISP's signature attendance sheet revealed several members of his interdisciplinary team were present, however, there was no evidence that Client #1 or a legal guardian was present at the meeting. 2. Interview with the QMRP on April 16, 2007 revealed all the client's in the facility including Client #2 participated in their Individual Support Plan (ISP) meetings and are encouraged to participate as much as possible. Review of the annual ISP meeting attendance record dated December 17, 2006 did not include Client #2's name. Further review of the ISP's signature attendance sheet revealed several members of his interdisciplinary team were present, however, there was no evidence that Client #2's legal guardian was present at the meeting.	W 209	W 209-1 In the future the Agency will ensure that the Guardian and client signatures will be included on the meeting attendance sheet to indicate attendance. Attached – Rights sheet to show client was present, and copy of attendance sheet. W 209 -2 Client #2's Guardian was informed about the meeting but was unable to attend due to personal reasons. Attached - meeting notification letter	5/8/07 5/8/07
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs	W 214		

PRINTED: 05/04/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09C155	A. BUILDING _____ B. WING _____	04/18/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	2755 SUDBURY ROAD, NW WASHINGTON, DC 20013

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 214	Continued From page 11	W 214		
	This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to ensure that Clients #1 and #3 was provided a comprehensive functional assessment that identifies the clients specific developmental and behavioral management needs. The finding includes: 1. The facility failed to ensure that a program objective was developed to train Client #1 to manage his finances. Interview with the Qualified Mental Retardation Professional (QMRP) and review of Client #1's habilitation record on April 18, 2007, revealed the client had an Individual Support Plan (ISP) dated July 18, 2006. The ISP contained a Money Management Assessment that was not dated. According to the assessment Client #1 was able to make small purchases with assistance and was able to identify variations of money. The assessment also indicated that the client could make change for a dollar, however, he was not able to make change for five, ten, twenty and fifty dollars. At the time of the survey, the facility failed to provide evidence that the client was being trained in skills necessary to increase his knowlege in managing his money 2. Client #3 was interviewed on April 17, 2007 11:15 AM, revealed that the client expressed an interest in utilizing public transportation to commute to and from his job, and go to and from		W 214-1 Client has a money management goal since his ISP in 7/06. Program frequency is once a week. Attached – Money Management Program and assessment and Data sheets W 214-2 Client #3 has had a comprehensive functional assessment – to evaluate and develop his traveling skills. He has a simulated program developed. In the future the Agency will ensure that all clients have a comprehensive functional assessment prior to program program implementation. Attached – Monthly QA system Functional Assessment sheets	5/8/07 5/8/07

PRINTED: 05/04/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
09G155		04/18/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	WASHINGTON DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 214	Continued from page 12 Union Station with his girlfriend. He stated that he was learning how to utilize the bus and the subway. Later that afternoon, staff were observed asking client #3 questions about the use of public transportation/simulated travel and the items that he would need to be successful. On April 18, 2007 at approximately 3:00 PM, an interview was held with the facility's Qualified Mental Retardation Professional (QMRP) to verify information revealed in the client's interview and programming observations. The QMRP verified that Client #3 was identified with the need for a community travel program at his 9/7/06 Individual Support Plan (ISP); therefore a formal objective had been established. Record verification completed in the ISP record on April 18, 2007 at 10:00 AM evidenced an IPP objective to develop various travel training skills, however the record failed to evidence an assessment to determine his strengths, needs and supports while travelling in the community. There was no evidence that the QMRP had ensured prior to program implementation, that an assessment had been completed.	W 214		
W 225	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that clients received comprehensive vocational assessments as indicated, for one of the three clients in the sample. (Client #1) The finding includes.	W 225		

PRINTED: 05/04/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE

PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE

W 220 Continued From page 17 W 220

On April 17, 2007, beginning at approximately 10:57 AM, Client #1 was observed at his day program. The client was weaving strands of string on a pot holder loom. He remained focused on the task, while his assigned 1:1 staff person stood in an adjacent hallway.

When asked about the client's skills, a day program staff indicated that the client was able to read and he could write his last name. The day program activities coordinator indicated the client's programs focused on recreation and leisure activities such as making jewelry and painting.

The ISP recommended that the day program develop an objective to perform 6 prevocational tasks within 12 months. Review of both the day program and residential IPP failed to reflect prevocations objectives. Additionally, there was no evidence that the client had been assessed to determine vocational needs.

The Qualified Mental Retardation Professional (QMRP) was interviewed later that day in the facility. At approximately 2:40 PM, she stated that Client #1 had not received a comprehensive vocational assessment.

W 225
Refer to W 120

5/9/07

W 242 485.440(c)(5)(iii) INDIVIDUAL PROGRAM PLAN W 242

The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of

PRINTED: 05/03/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY

NAME OF PROVIDER OR SUPPLIER: METRO HOMES

ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSSED-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
W 242	Continued from page 14 accuring them.	W 242		
	This STANDARD is not met as evidenced by: Based on observations, interview, and record review, the facility failed to ensure needed personal hygiene skills respectively was provided for one of the three clients in the sample. (Client #2). The findings include: The facility failed to ensure that a program was developed to train Client #2 to wash his hands appropriately. Client #2 was observed on the evening of April 17, 2007 at 5:32 PM independently washing his hands. The facility's nurse verbally prompted the client to wash his hands before taking his medication. The client was observed to independently turn on the faucet to wash his hands. He proceeded to put some liquid soap in his hands, afterwhich he rinsed the soap out of his hands before he rubbed his hands together to lather up the soap. Interview with the Qualified Mental Retardation Professional (QMRP) and review of Client #2's Individual Program Plan (IPP) dated December 17, 2006 revealed the facility failed to provide evidence that the client was being trained in skills necessary for washing his hands.		W 242 A hand washing Program has been developed for client #2. In the future the Agency will ensure that the IPP will include training in personal and hygienic skills for individuals requiring them. The Agency has a monthly QA audit system instituted. Attached – IPP hand washing – this will be presented to the IDT at the 2Q meeting and if approved staff will be trained and program started.	5/9/07
W 283	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a	W 283		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/08/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G155	A. BUILDING _____ B. WING _____	04/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	2268 SUDBURY ROAD, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 263	Continued From page 15 minor) or legal guardian. This STANDARD is not met as evidenced by: Based on interview and record review, the facility's Human Rights Committee (HRC) failed to ensure written informed consent had been obtained from the client and/or their legal guardian for the use of behavior support plans, for one of the three clients in the sample. (Clients #2) The finding includes: Observation of the evening medication administration on April 17, 2007, revealed that Client #2 received Risperdal 2mg. Interview with the medication nurse during the administration of the medication revealed the medication was used to manage behaviors. Interview with the Qualified Mental Retardation Professional (QMRP) on April 17, 2007 at 2:10 PM revealed that Client #2 received psychotropic medications and had a Behavior Support Plan (BSP). Review of Client #2's BSP dated July 6, 2006 revealed the plan addressed a targeted behavior of physical aggression. Further interview with the QMRP on April 18, 2007 revealed Client #2's mother was his legal guardian. This information was verified by the review of Client #2's habilitation record. Further review of the record revealed that Client #2 had a Psychological Assessment dated July 6, 2006. According to the assessment, Client #2 " is not competent to make independent decisions concerning his residential and day placements, program plan, medical treatment, or financial	W 263	W 263 Refer to W 124 Attached HRC meeting Approval sheet Signed consent form	5/8/07

PRINTED: 05/03/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G155	A. BUILDING _____ B. WING _____	04/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	2268 SUDBURY ROAD, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 263	Continued From page 16 affairs. He lacks the cognitive judgment and academic skills to understand the implications of these decisions, and therefore cannot give his informed consent." Client #2's mother visited the facility on April 18, 2007 at 12:00 PM. At 4:22 PM,the QMRP submitted an informed consent for Client #2's psychotropic medication. The consent had been signed by his legal guardian on the day of the survey (April 18, 2007). At the time of the survey, the facility failed to provide evidence that its Human Rights Committee had obtained written informed consent for the use of Client #2's psychotropic medication. [Also See W124]	W 263		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure general and preventive care for one of the three clients included in the sample. (Client #1) The finding includes: The facility failed to ensure that lab work was conducted to check Client #1's thyroid as evidenced below: Interview with the facility's LPN on April 18, 2007 revealed that Client #1 had lost nine pounds in one month. According to the nurse, the Qualified	W 322	W 322 The nurse has documented the nutritionist's recommendation and communication to the Primary Physician, on the nursing progress notes. The client has had his TSH done and is WNL. The nurse was in serviced on nursing documentation procedure. In the future the Agency will ensure that all consultant recommendations and orders are documented and completed in a timely manner – Audit System instituted Attached – nursing documentation P&P - Nursing progress note - -lab results - weight chart - -in service sign in sheet - Nursing Audit System	5/9/07

PRINTED: 05/03/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G155	A. BUILDING _____ B. WING _____	04/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	2268 SUDBURY ROAD, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 322	Continued From page 17 Mental Retardation Profession (QMRP) contacted the Nutritionist to inform her and to request a consult for the client. Further interview and record review of Client #1's Medical record on April 18, 2007 at approximately 12:18 PM revealed a nutritional progress note dated April 7, 2007. The note revealed a recommendation for weekly weights and for the client to get lab work for his thyroid level. When questioned if the PCP was informed of the nutritionist's recommendation, the nurse indicated that she informed the PCP. There was no documented evidence however that it was communicated. At the time of the survey, the facility failed to address the nutritionist recommendations.	W 322		
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on record review, the facility failed to ensure timely dental services, for one of the two clients in the sample. (Client #1) The finding includes: Review of Client #1medical records on April 18, 2007 at 9:26 AM revealed that he had a dental consultation on March 16, 2006. During the visit the client was recommended to return in six months. Further review of the records revealed	W 356	W 356 The Client has been scheduled to return to the dentist on 5/22/07 for cleaning and prophylaxis as his Medicaid Authorization has been approved. In the future the Agency will ensure that all client consults and recommendations are completed in a timely manner. The Agency has hired a Director of Nursing and has changed nursing oversight to the clients. There is a Quarterly Medical and Nursing QA System which has been instituted.	5/9/07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/03/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G155	A. BUILDING _____ B. WING _____	04/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	2268 SUDBURY ROAD, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 356	Continued From page 18 the client was not seen until February 13, 2007, eleven months later. At the time of the survey, the facility failed to ensure that the client received his recommended dental services.	W 356		
W 371	483.460(k)(4) DRUG ADMINISTRATION The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure clients are taught to administer their own medications, for two of the three clients (Clients #1 and #2) included in the sample. The findings include: Observation of the evening medication administration on April 17, 2007 beginning at 5:32 PM revealed Clients #1 and #2 received their medications from the licensed practical nurse. Further observation of the evening medication administration pass revealed the following: 1. Client #1's medications were administered by the nurse. The nurse called the client to come to take his medication and was instructed to bring a glass of water with him. Client #1 was observed to bring a glass of water independently to the area where the medication was being administered. The nurse gave the medication cup to the client. The client was observed to take all of his medication and proceeded to drink his water	W 371	W 371-1 All the clients in this Facility have been re assessed for Self Administration of medication and a Self Medication Training program has been put into place to enhance their skills. In the future the DON will QA each client's records to ensure that they are receiving the appropriate medical and nursing care. Attached – Nursing QA checklist - Self Med assessments for the clients - Medication Training Programs	5/9/07

PRINTED: 05/03/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G155	A. BUILDING _____ B. WING _____	04/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	2288 SUDBURY ROAD, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 371	Continued From page 19 independently. Review of Client #1's medical record on April 18, 2007 at 3:45 PM revealed a self -medication assessment dated July 13, 2006. According to the assessment, Client #1 was recommended a self- medication program and review of the IPP did not reflect a program. 2. Client #2 was observed to bring a pitcher of water and a cup independently to the area where his medication was being prepared. The nurse was observed to hand the client a medication cup that had his pills in it mixed with applesauce using a spoon. Client #2 fed himself his medication independently. Interview with the nurse on April 17, 2007 revealed Clients #1 and #2 had self medication programs that were kept in the client's Medical book. The facility's nurse proceeded to look in both clients medical records, however, there was no documented evidence of self-medication program objectives. At the time of the survey, the facility failed to determine an appropriate training program to enhance the clients self-medication skills.	W 371		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview and record	W 436		

PRINTED: 05/03/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G155	A. BUILDING _____ B. WING _____	04/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	2268 SUDBURY ROAD, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 436	Continued From page 20 review, the facility failed to furnish adaptive equipment for one of three clients in the sample. (Client #2) The finding includes: Observations at the day program on the same day at 12:24 PM,revealed Client #2 eating his lunch using a regular plate. On April 17, 2007 at 7:07 PM, Client #2 was observed eating his dinner using a scoop plate. Review of the habilitation record on April 18, 2007 at approximately 9:00 AM revealed that the client had an Occupational Therapy Assessment dated October 30, 2006. A recommendation was made to "discontinue the use of a plate guard at meatime and replace with a scoop dish." Interview with the QMRP on April 18, 2007 revealed that the client was to have a scoop plate at the day program. At the time of the survey, there was no evidence that the facility provided the day program with the necessary adaptive equipment	W 436	W 436 Refer to W 159	
W 448	483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills, including accidents. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to have a system to identify problems encountered with evacuation drills for all six clients that reside in the facility. The finding includes:	W 448		

PRINTED: 05/03/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G155	A. BUILDING _____ B. WING _____	04/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	2268 SUDBURY ROAD, NW WASHINGTON, D C 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 448	Continued From page 21 At 10:30 AM on 4/18/07 records of evacuation drills from April 2006 through March 2007 were reviewed. The format used by the facility to document drills did not include identification of problems encountered during the drills. Further review of the fire drill reports failed to evidence that the evacuation drills were being reviewed by the House Manager (HM) and or by the Qualified Mental Retardation Professional (QMRP). Interview with the QMRP and HM on April 19, 2007 at 11:15 AM verified that both the HM and the QMRP were responsible for monitoring, reviewing, identifying problems and signing off, however to date, there was no documented evidence of these reviews.	W 448	W 448 The Agency has revised the Fire Drill Report to include review by the QMRP and House Manager to monitor the efficacy of the Fire Drill. It will also reflect the problems/ concerns encountered during the Fire Drill. Attached – Revised Fire Drill Report	5/9/07
W 484	483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure dining supplies and adaptive equipment were provided to meet the developmental needs of five of six clients residing in the facility. (Clients #1, #2, #3, #5, and #6) The findings include: a. During dinner observation on April 17, 2007, Clients #1, #2, #3 #5 and #6 were observed eating their prepared meals. The clients were not offered condiments, such as salt or pepper and there were no condiments available in the dining room.	W 484	W 484 a. - In the future the Facility will ensure that Condiments are readily available to the clients, if they should need it. b - Refer to W-159	5/9/07

PRINTED: 05/03/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G155	A. BUILDING _____ B. WING _____	04/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	2268 SUDBURY ROAD, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 484	Continued From page 22 An interview was conducted with the QMRP and a direct care staff on April 18, 2007 at approximately 3:30 PM. According to the Qualified Mental Retardation Professional (QMRP), the facility does not use salt or supply condiments on the table. Further interview with the direct care staff revealed seasonings are used while they are preparing the food and during the cooking of the food. b. On April 17, 2007 at 7:07 PM, Client #2 was observed eating his dinner using a scoop plate. Observations at the day program on the same day at 12:24 PM, revealed Client #2 eating his lunch using a regular plate. Review of the habilitation record on April 18, 2007 at approximately 9:00 AM revealed that the client had an Occupational Therapy Assessment dated October 30, 2006. A recommendation was made to "discontinue the use of a plate guard at mealtime and replace with a scoop dish." At the time of the survey, there was no evidence the scoop plate had been provided for the client at his day treatment program.	W 484		

PRINTED: 05/03/2007
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G155	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/19/2007
NAME OF PROVIDER OR SUPPLIER METRO HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 2268 SUDBURY ROAD, NW WASHINGTON, DC 20012		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 000	INITIAL COMMENTS The licensure survey was conducted on April 17, 2007 through April 19, 2007. A random sample of three residents was selected from a residential population of six males with mental retardation and other disabilities. The findings of the survey were based on observations, interviews and review of resident and administrative records.	I 000		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: The findings include: During the environmental inspection on April 19, 2007 the following concerns were observed: Outside The outside carpet on the entrance stairs leading to the front door, had large ripped areas that posed a safety risk to any person entering into this facility. Kitchen 1. One of the cabinet doors on the small hutch, was observed broken and hanging from the hinge, posing a safety risk for the residents that reside in this facility. Residents were observed through out the licensure process to utilize this hutch to obtain pots and pans for meal	I 090	I 090 The carpeting to the entrance stairs will be replaced. In the future the Agency has instituted a monthly QA System to ensure that the environment is safe and esthetically pleasing for the clients. Attached – Monthly Infection Control and Environmental survey sheet	5/14/07

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] BCN, MA TITLE [initials] (X6) DATE 5/9/07

PRINTED: 05/03/2007
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G155	A. BUILDING _____ B. WING _____	04/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	2288 SUDBURY ROAD, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 192	Continued From page 2 The GHMRP failed to ensure that four professional staff had liability insurance proof filed in their personnel files.	I 192	I 192 See attached Liability Insurance	5/9/07
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current health certificates for all employees annually. The finding includes: Review of the personnel files on April 18, 2007, the GHMRP failed to provide current health certification for two (2) consultants [[redacted], [redacted]].	I 206	I 206 Health Certificates for [redacted], [redacted] are attached. In the future the Agency will ensure that HR Personnel will review the Staff database periodically to update expired certificates. Attached – health certificates – [redacted]	5/9/07
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure the protections of each.	I 500	I 500 Refer to W 124, W 149	

PRINTED: 05/03/2007
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G155	A. BUILDING _____ B. WING _____	04/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	2268 SUDBURY ROAD, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 090	Continued From page 1 preparation. 2. The stove exhaust fan filter had evidence of heavy grease.	I 090	I 090 – 1 The Hutch in the Kitchen has been replaced. The stove exhaust filters have been ordered through Sears. The Agency has instituted Environmental QA system to ensure that the environment is safe and orderly. Attached - QA System	5/9/07
I 161	3507.2 POLICIES AND PROCEDURES The manual shall be approved by the governing body of the GHMRP and shall be reviewed at least annually. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP governing body failed to review its policies and procedures annually. The finding includes: Interview and review of the policy and procedure manual on April 18, 2007 failed to provide evidence that the agency's policy manual had not been reviewed and approved by the governing annually as required. The last noted date for review was on 3/13/06.	I 161	I 161 The Agency has ensured that all Policy and Procedure books provided in the facilities have been reviewed and approved by the governing body annually. In the future the Agency will ensure that at the Beginning of each year and with the change or addition of any Policy and Procedure that the books are accordingly updated. Attached – copies of the annual administrator review of the P&P Books	5/9/07
I 192	3508.8(c) ADMINISTRATIVE SUPPORT Each GHMRP licensee shall carry or ensure that the premise carries the following insurance in at least the following amounts: (c) Professional Liability This Statute is not met as evidenced by: The findings include:	I 192		

PRINTED: 05/03/2007
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G155	A. BUILDING _____ B. WING _____	04/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	2268 SUDBURY ROAD, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 500	Continued From page 3 clients rights. The findings include: [See Federal Deficiency Report - Citations W124 and W149].	I 500		